

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02662

Reg. Dist. No. 95

1. PLACE OF DEATH:

County..... Cecil
City or town..... Calvert
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Cecil.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Anderson

3. (b) Social Security Number

4. Sex..... F..... 5. Color or race..... W..... 6. (a) Single, married, widowed, or divorced..... Single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... (No Record) about 1868

8. AGE: Years..... About 80..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Scotland.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Henry Anderson

13. Birthplace..... Scotland

MOTHER 14. Maiden name..... Agnes

15. Birthplace..... Scotland

16. Informant..... Robert McAlister
Address..... Oxford Pa

17. Burial..... Date thereof..... March 28-48
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory..... Rosebank Calvert Md

Location..... Calvert, Md

18. Funeral director..... J. E. Johnson

Address..... Rising Sun Md

19. Mcm- 48..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3-25..... 19.48, at 11:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept..... 19.47, to March..... 19.48

and that I last saw him alive on 3-23..... 19.48

Immediate cause of death..... Lobor Pneumonia..... DURATION 48 hrs.

Due to..... Sen. I. Ex

Due to..... Myocardial Infarction

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

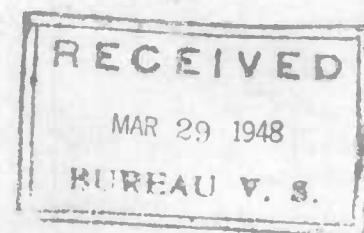
Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... But D. S. S. L. Date signed 3-25-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02663

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town Childs
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil
City or town Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

George W. Blackson

3. (b) Social Security Number

212-16-8045

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Louella Blackson

7. Birth date of deceased (mo., day, yr.) November 4, 1873 6. (c) If alive, give age years

8. AGE: Years 74 Months 4 Days 21 If less than one day hrs. min.

9. Birthplace Cherry Hill, Cecil Co., Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business U.S. Public Health. Retired

12. Name Aeron Blackson

13. Birthplace Cecil Co., Md.

14. Maiden name Mary Mahan

15. Birthplace Cecil Co., Md.

16. Informant Louella Blackson

Address Childs, Cecil Co., Md.

17. Burial (Burial, cremation, or removal. Which?) March 28, 1948
(month) (day) (year)

Cemetery or crematory Principio

Location Principio Furnace, Md.

18. Funeral director W. A. Patterson & Son

Address Perryville, Md.

19. Mar 26 1948 (Date rec'd by registrar) J. R. Trager Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25, 1948 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 19 48 to March 25 19 48 and that I last saw him alive on 3/23 19 48

Immediate cause of death Coronary occlusion DURATION

Due to Cardiac renal vascular disease

Due to

Other conditions Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Patterson & Son M. D. or other

Address Perryville, Md. Date signed 3/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02664

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

8. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

8. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial or removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Mar 19 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

County

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

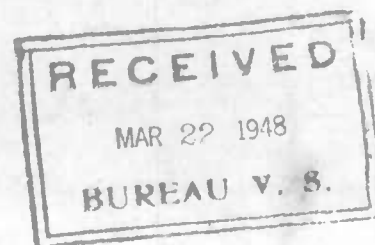
23. SIGNATURE

Medical Examiner

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02665

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Beech
City or town Elkton RD 5
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Beech
City or town Elkton - RD 5 Cherry Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2. (a) If veteran, name war not a veteran

3. (a) FULL NAME

Larry Herbert Davis

3. (b) Social Security Number

none

4. Sex Male 5. Color of race White 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife Amie C. Jacques

Deceased 1938 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct 30 - 1862

8. AGE: Years 85 Months 4 Days 26 It less than one day _____ hrs. _____ min.

9. Birthplace Beech County - MD
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business Retired

12. Name James Davis

13. Birthplace Maryland

14. Maiden name Louise Metcalf

15. Birthplace England

16. Informant Mrs Edna D. Hillgard

Address Elkton, Md RD 5

17. Burial Date thereof Mar 30 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Cherry Hill Maryland

18. Funeral director Joseph R. Grant

Address North East Md

19. Mar 30 48 Registrar H. J. Dwyer
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 48 at 11 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 48 to Mar 26 - 48

and that I last saw him alive on March 26 48

Immediate cause of death Cardio-vascular-renal disease DURATION about 14 yrs

Due to _____

Due to _____

Other condition General atherosclerosis unknown

Large Colloidal goiter 40y (phs)
(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Mens of injury _____ Injured at work? _____

23. SIGNATURE J. J. M. Dwyer M. D. or other _____

Address Elkton - Md Date signed 3/27/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02666

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
 City or town Elkton
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

 210 E High St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil
 City or town Elkton Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 210 E High St
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

 Baby Richard Larry Frederick.

3. (b) Social Security Number

4. Sex M. 5. Color or race Wh 6. (c) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

 Mar. 7, 1948

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

it less than one day

 2 1/2

hrs.

min.

9. Birthplace

 Elkton Md

(Town, county, and state)

10. Usual occupation

 None

11. Industry or business

FATHER

12. Name

 Edward Frederick

13. Birthplace

 North East, Md

MOTHER

14. Maiden name

 Doris S. Jackson

15. Birthplace

 Elkton Md

16. Informant

 Edward Frederick

Address

 Elkton Md

17. Burial

(Burial, cremation, or removal. Which?)

Data thereof

 Mar. 10/48
(month) (day) (year)

Cemetery or crematory

 Elkton

Location

 Elkton Md

18. Funeral director

 H W Pippin

Address

 Elkton Md

19. Mar 10

19 48

(Date rec'd by registrar)

 FR Trazar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 48 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

 March 7 19 48 to March 9 19 48 and that I last saw him alive on March 8 19 48

Immediate cause of death

 Convulsions

DURATION

 1 day

Due to

 Underlying cause not established
(5/4/48 ok)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

 James L. Johnson M.D.

M. D. or other

Address

 Elkton Md Date signed 3/10/48

MARGIN RESERVED FOR BINDING

VS 415

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

02667

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 da.

Hospital, institution, or street address where death occurred:
Union Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)Street No. Biddle
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bentha Grabowski.

3. (b) Social Security Number

4. Sex F. 5. Color or race wh 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Joseph Grabowski

T. Birth date of deceased (mo., day, yr.) August 11 1904

8. AGE: Years 43 Months 7 Days 17 hrs. min.

9. Birthplace Wilkiborough Pa
(Town, county and state)

10. Usual occupation at home

11. Industry or business

12. Name John Jovovski

13. Birthplace Poland

14. Maiden name Mrs. Jov.

15. Birthplace

16. Informant Joseph Grabowski

Address Chesapeake City Md

17. Burial Date thereof June 20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Rose's Catholic

Location Chesapeake City, Md

18. Funeral director H.W. Pappas

Address Elkton Md

19. March 29, 1948 J.R. Frazer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27, 1948 at 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1948, to March 27, 1948, and that I last saw him alive on March 27, 1948

Immediate cause of death

uremia

Due to

Chronic

glomerulo-nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

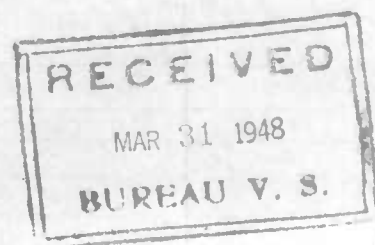
Means of injury injured at work?

23. SIGNATURE

Address 202 E. Main St

Date signed 3/29/48

Elkton, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02668

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **CECIL**
 City or town..... **PERRY POINT, MD.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **1 month 9 days**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Maryland
 How long in hospital or institution? **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1315 W. Fayette Street**
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ☒

3. (a) FULL NAME

MARY A. M. HACKER

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Wid.

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

September 6, 1874

8. AGE:

Years

Months

Days

If less than one day

73**6****12**

hrs.

min.

9. Birthplace

Berlin, Wisc.

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

18. Informant

Hospital Records

Address

VAH, Perry Point, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

3-18-48
(month) (day) (year)

Cemetery or crematory

Greenlawn Cemetery

Location

Cambridge, Maryland

18. Funeral director

Havre de Grace, Md.

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **March 18th** 19. **48** at **12:55 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 9th 19. **48** to **March 18th** 19. **48**
 and that I last saw him **er** alive on **March 18th** 19. **48**

Immediate cause of death

DURATION

Carcinomatosis, diffuse, abdominal**1 months**

Due to

Adenocarcinoma, stomach**9 months**

Due to

Other conditions **Arteriosclerosis,**
generalized

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations **Same as above**Date of op. **2-20-48**Autopsy results **No autopsy**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

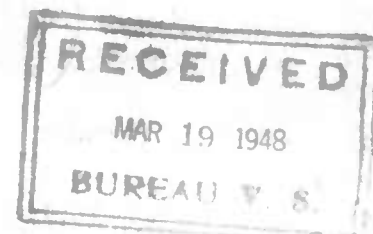
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE **A. E. TROLLINGER, M.D., Chf. Prof. Serv.**
VAH, Perry Point, Md.
 M. D. of other.....
 Address..... Date signed.....



3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02660

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elk Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County CecilCity or town Elk Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Henery J. Haley

3. (b) Social Security Number

none4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 21 18738. AGE: Years 74 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Penna.
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Patrick Haley13. Birthplace Ireland14. Maiden name Maryann Quigley15. Birthplace Ireland16. Informant Charles HaleyAddress Cecilton MD.17. Burial Date thereof March 24 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GalenaLocation Galena MD.18. Funeral director Edward FellowsAddress Millington MD.19. Mar 22 19 48 JH Frager
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948 at 7:20 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 18 1948 to March 21 1948and that I last saw him alive on March 20 1948Immediate cause of death Myocardial infarction
coronary disease

DURATION

3 years

Due to _____

Due to _____

Other conditions ArteriosclerosisUnderlying cause: Nephritis (associated with
(Include pregnancy within 3 months of death) CRC disease) (Bp 140/90)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____Where did injury occur? _____
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) No

Means of injury _____ Injured at work? _____

23. SIGNATURE Th J Darrow MD M. D. or otherAddress Chesterbrook, Md Date signed 3/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-15-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11999

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RECEIVED

MAR 24 1948

BUREAU V. S.

3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02670

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County..... Elkton
 City or town..... Elkton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 3 days
 Hospital, institution, or street address where death occurred:
Union Hospital - Elkton, Md
 How long in hospital or institution?..... 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State..... Rising Sun..... County..... Cecil
 City or town..... Thaylora
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Maisha Ann Harding

3. (b) Social Security Number

4. Sex..... Female
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... David Harding
deceased
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... July 10 - 1864
 8. AGE: Years..... 83 Months..... 7 Days..... 11
 If less than one day..... hrs. min.

9. Birthplace..... Chester County - Pa
 (Town, county, and state)
 10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Samuel Sweet

13. Birthplace..... Chester Co., Pa

14. Maiden name..... Eliza Jane Hale

15. Birthplace..... Cecil Co., Md.

16. Informant..... Mrs Edwin F. Fiken

Address..... Conowingo, Md.

17. Burial Date thereof..... 3-25-1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Oxford Cemetery

Location..... Oxford Pa.

18. Funeral director..... Ralph M Reed

Address..... Rising Sun Md

19. Mar 22 19 48 FR Frazier
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 21 19 48 at 12.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 1948 19 48, to March 21 19 48
 and that I last saw or alive on March 21 19 48

Immediate cause of death..... Cardio-vascular renal
disease with
gangrene of left foot

Due to..... 1 week

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

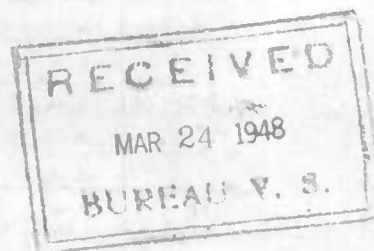
Injured at home, farm, industry, public place (where)?.....
 Means of injury..... Injured at work?

23. SIGNATURE..... J. H. McKnight
 M. D. or other.....
 Address..... Elkton - Md. Date signed..... 3/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02671

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Lucile
City or town Cecilton - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Union Hosp.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Lucile
City or town Cecilton - Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2. (a) If veteran, name war _____

3. (a) FULL NAME

Mary Frances Harrison

3. (b) Social Security Number

4. Sex Female 5. Color or race negro 6. (a) Single, married, widowed, or divorced Widow
6. (b) Name of husband or wife Edward Harrison
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Oct 12 - 1864

8. AGE: Years 83 Months 5 Days 15 It less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name unknown

13. Birthplace _____

14. Maiden name unknown

15. Birthplace _____

16. Informant Samuel Harrison

Address 1003 S. Dorrance St Phila Pa

17. Burial Date thereof 4.3.48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cecilton, Md.

Location _____

18. Funeral director Austin O. Caultk.

Address 827 Pine St Wilm. Del.

19. April 2 19 48 F.R. Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 48 at 6.05 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 48 to March 30 19 48

and that I last saw him alive on March 29 19 48

Immediate cause of death Cerebral hemorrhage with hemorrhage DURATION 17 days

Due to _____

Due to atherosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE T.H. McLaughlin M. D. or other _____

Address Cecilton - Md Date signed 3/30/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1948

BUREAU V. S.

1948
March 12
1948

1948
March 12
1948

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March 12
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RECEIVED
APR 3 1948
BUREAU V S

1948
March 12
1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **CECIL**
 City or town..... **PERRY POINT, MD.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **25 days**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution?..... **Two years**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Virginia** County..... **Pittsylvania**
 City or town..... **Danville**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **Calhoun Street**
 (If rural, give LOCATION)
WW-I
 2.(a) If veteran, name war.....

3. (a) FULL NAME

EDWARD LINDSAY

3. (b) Social Security Number

4. Sex..... **Male**
 5. Color or race..... **White**
 6. (a) Single, married, widowed, or divorced..... **W**

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... **February 2, 1894**
 6. (c) If alive, give age..... years

8. AGE: Years..... **54** Months..... **1** Days..... **7** If less than one day..... hrs. min.

9. Birthplace..... **Virginia**
 (Town, county, and state)

10. Usual occupation..... **Textile Worker**

11. Industry or business.....

12. Name..... **Jim Lindsay - Deceased**

13. Birthplace..... **Virginia**

14. Maiden name..... **Sarah Coles - Deceased**

15. Birthplace..... **Virginia**

16. Informant..... **Hospital Records**

Address.....

17. **Removal** Date thereof..... **3/10/48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Unknown**

Location..... **Danville, Va.**

18. Funeral director..... **Funerary of Dan**

Address..... **Havre de Grace, Maryland**

19. **March 10** 19 **48** **Irma E. Daugherty**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **March 9th** 19 **48** at **12:45 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 14th 19 **48** to **March 9th** 19 **48**
 and that I last saw him alive on **March 9th** 19 **48**

Immediate cause of death..... **Myocardial degeneration** DURATION **14 days**

Due to **Tuberculosis, pulmonary, far advanced, active** Unknown

Due to.....
 Other conditions **Asthma, bronchia, severe** **5 yrs.**

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... **No autopsy**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE **A. E. TROLLINGER, M.D., Chf., Prof. Servs.**
 M. D. or other

VAH, Perry Point, Md. Date signed **3-10-48**

RECEIVED

MAR 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH: Cecil
County..... ELKTON
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
UNION HOSPITAL
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... MARYLAND County..... Cecil
City or town..... Chesapeake City, 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME WALLACE LOGUE
4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband or wife EMMA LOGUE
7. Birth date of deceased (mo., day, yr.) MARCH 14 - 1885
6.(c) If alive, give age..... years

8. AGE: Years 62 Months 11 Days 19 If less than one day
..... hrs. min.

9. Birthplace..... Chesapeake City, Cecil, Md.
(Town, county, and state)

10. Usual occupation..... ENGINEER

11. Industry or business.....

12. Name..... FRANK LOGUE

13. Birthplace..... MARYLAND

14. Maiden name..... MARY ELLA WORTZ

15. Birthplace..... ?? - MARYLAND ??

16. Informant..... HOSPITAL RECORDS

Address..... UNION HOSPITAL, ELKTON, MD.

17. Burial Date thereof..... 3/5/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Bethel Mor Chesapeake City

Location..... Chesapeake City, Md

18. Funeral director..... Mr. Lippitt

Address..... Elkton, Md

19. Mar 3 1948 IR Trager
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 2 1948 at 10¹⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1948 to March 2 1948 and that I last saw him alive on March 2 1948

Immediate cause of death.....

Coronary heart disease 3 weeks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature..... S. R. R. Anderson, Jr., M.D.

Elkton, Maryland Date signed 3/2/48

Address.....

RECEIVED

MAR 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 596

02675

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil
City or town Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Perryville, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

WILBUR WESTON NICKLE

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Margaret A.
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1872

8. AGE: Years 75 Months 4 Days 28 If less than one day hrs. min.

9. Birthplace Rising Sun, Cecil Co., Md.
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business B & O Railroad

12. Name Samuel Cooley Nickle

13. Birthplace Cecil Co., Md.

14. Maiden name Margery E. Foster

15. Birthplace Cecil Co., Md.

16. Informant Margaret A. Nickle

Address Perryville, Md. R.F.D.

17. Burial Date thereof 3-18-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Principio

Location Principio Furnace, Maryland

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. 3/18 48 Irene Daugherty
(Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1947 to March 16, 1948 and that I last saw him alive on March 15, 1948

Immediate cause of death Arthritis Deformans DURATION 25 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Magraw M. D. another

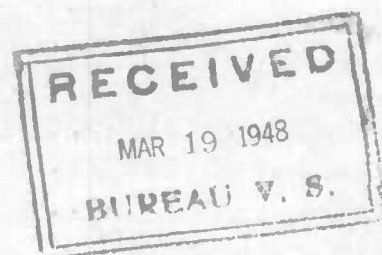
Address Perryville, Md. Date signed 3/17/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

02676

CERTIFICATE OF DEATH

Reg. Dist. No. 90 90

1. PLACE OF DEATH:

County CecilCity or town Hacks Point, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Hacks Point Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Theresa Emma O'Neil

3. (b) Social Security Number

4. Sex

F.

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 2, 18768. AGE: Years 71 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Pent Co. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Nicholas George13. Birthplace Germany14. Maiden name Marsukite Bobby15. Birthplace Switzerland16. Informant Clarence O'NeilRural Earlville Md.17. Burial Date thereof March 11-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cemetery - GalenaLocation Galena Md.18. Funeral director Edward F. HollowayAddress Millington, Md.19. March 10 1948 Mrs. Harver W. Cheyne
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1948 at 8 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1947 to March 8 1948 and that I last saw him alive on March 7 1948Immediate cause of death Cerebral hemorrhage and thrombusDue to arterio sclerosisDue to hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Theresa F. Paproski MD M. D. or otherAddress Galena Md Date signed 3-9-48

RECEIVED
MAR 12 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02677

94

1. PLACE OF DEATH:

County CecilCity or town North East
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town North East
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Edgar Allan Poe

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Margaret Poe

7. Birth date of deceased (mo., day, yr.)

Jan 29 1865

6. (c) If alive, give age, years

8. AGE:

33 Years 1 Months 12 Days

If less than one day

hrs. min.

9. Birthplace

North East Cecil Md
(Town, county, and state)

10. Usual occupation

Retired Salesman

11. Industry or business

Thomas B Poe

MOTHER FATHER

12. Name

Thomas B Poe

13. Birthplace

Baltimore Md

14. Maiden name

Eliza B Baulden

15. Birthplace

Md

16. Informant

Mrs Margaret Poe

Address

North East Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Burial May 15 1998
(month) (day) (year)

Cemetery or crematory

Methodist

Location

North East Md

18. Funeral director

Joseph H. Frank

Address

North East Md

19.

(Date rec'd by registrar)

3/18- 1948 Lida & Circus
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1948 at 2 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21 1948 to Mar. 12 1948and that I last saw him alive on Mar. 10 1948Immediate cause of death Myocarditis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

O B Collins M. D. or otherAddress North East Md Date signed 3-13-48

RECEIVED

MAR 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02678

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

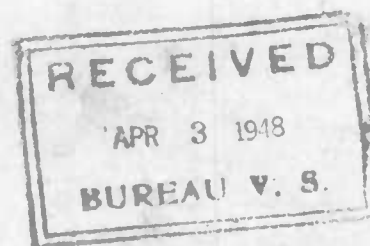
23. SIGNATURE

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02679

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Cecil
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Cecil
City or town Port Deposit Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Laura Frances Rea.

3. (b) Social Security Number

4. Sex F. 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William Rea.

7. Birth date of deceased (mo., day, yr.) Oct 27, 1876. 6. (c) If alive, give age 73 years

8. AGE: Years 71 Months 5 Days 1 It less than one day hrs. min.

9. Birthplace Rock Spruce Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Samuel L. Pierce

13. Birthplace Oakwood Md.

14. Maiden name Rebecca Councilman

15. Birthplace Pa.

16. Informant Wm Rea.

Address Port Deposit Md.

17. Burial Date thereof April 1, 1948 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brookview

Location Rising Sun Md.

18. Funeral director J. E. Tyson.

Address Rising Sun Md.

Mch 31, 1948

ISSUED 3-31-48

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1948, at 1030 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 to 19 and that I last saw him alive on 18

Immediate cause of death Acute Coronary Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. E. Dodson

Address Rising Sun Md

Medical Examiner

for Cecil County

M. D. or other

3/29-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

AW5 A15

PERMIT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02680

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours

Hospital, institution, or street address where death occurred

Elkton Hospital Elkton Md.

How long in hospital or institution? 2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Shelia Bae Rector

3. (b) Social Security Number

4. Sex F

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar-30 1947

8. AGE: Years 3 Months 5 Days If less than one day hrs. min.

9. Birthplace Elkton Md.
(Town, county, and state)

10. Usual occupation clerk

11. Industry or business

12. Name Bayne Rector

13. Birthplace Shanta, N.C.

14. Maiden name Edith Hargis

15. Birthplace North East Md.

16. Informant Bayne Rector

Address North East Md.

17. Burial Date thereof 3/8/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Northeast

Location North East md.

18. Funeral director Ralph M. Reed

Address Rising Sun md.

19. Mar 6 1948 F. H. Frazier

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1948 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Bilateral Lobar Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Medical Examiner

23. SIGNATURE

Rising Sun Md. Cecil County

M. D. or other

Date signed 3-6-48

RECEIVED

MAR 9 1948

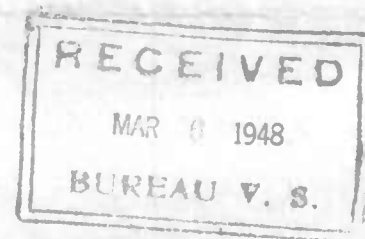
BUREAU V. S.

RECEIVED

MAR 23 1948

BUREAU V. S.

I



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02683

Reg. Dist. No. *92*

1. PLACE OF DEATH:

County *Becil*
City or town *Elkton*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *1 day*
Hospital, institution, or street address where death occurred
Union Hospital

How long in hospital or institution? *1 day*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Becil*
City or town *Elkton*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *Water Street*
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

June Ann Shockley

3. (b) Social Security Number

4. Sex *female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Oct 26 47* 6. (c) If alive, give age years

8. AGE: Years *4* Months *17* Days *17* If less than one day hrs. min.

9. Birthplace *Elkton - Md*
(Town, county, and state)

10. Usual occupation *none*

11. Industry or business

12. Name *Junior Estelle Alley*

13. Birthplace *Virginia*

14. Maiden name *June Ann Shockley*

15. Birthplace *Delaware*

16. Informant *Mother - June Ann Shockley*

Address *Water St Elkton, Md*

17. *Burial* (Burial, cremation, or removal. Which?) Date thereof *Mar 16 48*
(month) (day) (year)

Cemetery or crematory *Elkton*

Location *Elkton, Md*

18. Funeral director *H. W. Phipps*

Address *Elkton, Md*

19. *Mar 16 48* (Date rec'd by registrar) Registrar *H. J. Trager*

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 14 1948* at *7:30 P. M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar 13 - 1948* to *Mar 14 1948* and that I last saw him alive on *March 11 1948*

Immediate cause of death *Malnutrition, vomiting & diarrhoea & dehydration* DURATION *about 2 weeks*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

R. H. McHugh M.D.

23. SIGNATURE *Elkton - Md* M. D. or other

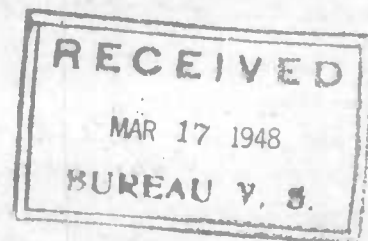
Address *Elkton - Md* Date signed *3/15/48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS AT5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County *Cecil*
 City or town *Port Deposit Rural.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *In road.*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Pa.* County *Lancaster*
 City or town *Lancaster*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *336 N. Mulberry*
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lieut Walter Elvin Smith

3. (b) Social Security Number

4. Sex *M.* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Divorced*

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) *1 May 1918*

8. AGE: Years *29* Months *10* Days *27* If less than one day
 hrs. min.

9. Birthplace *Lancaster, Penna.*
(Town, county, and state)10. Usual occupation *Army Officer*11. Industry or business *U. S. Army*12. Name *unknown (at present)*

13. Birthplace

14. Maiden name *unknown (at present)*

15. Birthplace

16. Informant *H. B. Richards 1st Lt USMC*Address *Registrar - Station Hospital, A.P.C. Md.*17. Transportation *Train* Date thereof *Mar 30 1948*
(Burial, cremation, or removal. Which?) (month, day, year)Cemetery or crematory *Chaff Funeral Home*Location *Lancaster, Penna.*18. Funeral director *Howard K. McBrumister*Address *Abingdon, Maryland*19. *April 3, 1948* *Irene E. Sanghera*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 28 1948* 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death *Acute Coronary Disease*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Blck Dodson MD
Therese Sun Md

Medical Examiner

for Cecil County

M. D. of other

Date *3/28-48*

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APR 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02685

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elleston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 hoursHospital, institution, or street address where death occurred: Union HospitalHow long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CecilCity or town Elleston R D 5
(If outside city or town limits, write RURAL and give nearest town)Street No. 777

(If rural, give LOCATION)

2.(a) If veteran, name war not a veteran

3. (a) FULL NAME

Arthur M Spratt

3. (b) Social Security Number

218-09-1815

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 13 1863

8. AGE: Years Months Days If less than one day

84 9 8 hrs. min.9. Birthplace Andora Cecil Co Maryland
(Town, county, and state)10. Usual occupation Fireman11. Industry or business Paper mill12. Name William H. Spratt13. Birthplace Maryland14. Maiden name Martha E. Jamison15. Birthplace Maryland16. Informant Charles H. SprattAddress Elleston R D 5 md17. Buried Date thereof 3-24-48

(Burial, cremation, or removal of which?) (month) (day) (year)

Cemetery or crematory SharpsLocation Fairhill, Cecil Co Md18. Funeral director Joseph R. HuntAddress Northeast Md19. Mar 24 19 48 FR Frazier

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1948 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on March 21 1948Immediate cause of death Vascular collapse

DURATION

12 hrs.Due to First, Second and Third degree burns of both lower extremities including genitals and buttocks.Other conditions Arteriosclerosis, advanced

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of March 20-48Where did injury occur? Andora Cecil Maryland

(City or town) (County) (State)

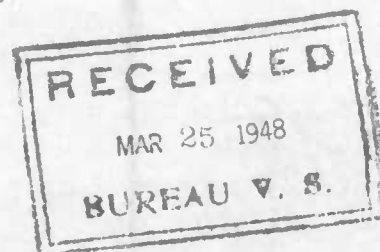
Injured at home, farm, industry, public place (where?) FarmMeans of injury field fire Injured at work? no23. SIGNATURE One Ford H. Spracher, M.D.Address Elleston Md acting as physician or otherDate signed March 21-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02686

CERTIFICATE OF DEATH

Reg. Diat. No.

92

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

B. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

77

6

19

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 20 1948 at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Medical Examiner

M. D. or other

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County... **CECIL**
 City or town... **PERRY POINT, MD.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... **19 yrs. 8 mos. 12 das.**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution?... **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Pennsylvania** County... **Philadelphia**
 City or town... **Philadelphia**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **5825 Willows Avenue**
 (If rural, give LOCATION)
 2.(a) If veteran, name war... **WW-I**

3. (a) FULL NAME

SALVATORE VALENTE

3. (b) Social Security Number

4. Sex... **Male** 5. Color or race... **White** 6.(a) Single, married, widowed, or divorced... **Married**
 6.(b) Name of husband or wife... **Margery D. Valente**
 7. Birth date of deceased (mo., day, yr.)... **May 9th, 1893**
 8. AGE: Years... **54** Months... **10** Days... **14** If less than one day... hrs. min.

9. Birthplace... **Philadelphia, Penn.**
 (Town, county, and state)

10. Usual occupation... **Unknown**

11. Industry or business

FATHER 12. Name... **Michael Valente**
 13. Birthplace... **Italy**

MOTHER 14. Maiden name... **Unknown**
 15. Birthplace... **Italy**

16. Informant... **Hospital Records**
 Address... **VAH, Perry Point, Md.**

17. Removal... **Removal** Date thereof... **3-24-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... **Woodlands**
 Location... **Woodland Ave., W. Phila., Penn.**

18. Funeral director... **Pennington & Son**
 Address... **Havre de Grace, Md.**

19. Date rec'd by registrar... **March 24, 1948** Registrar... **James E. Day**

MEDICAL CERTIFICATION

20. DATE OF DEATH... **March 23rd** 19 **48** at **4:25 P. M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
July 11th 19 **28**, to **March 23rd** 19 **48**

and that I last saw him alive on **March 23rd** 19 **48**

Immediate cause of death... **Pneumonia, bil., lobular** DURATION... **2-3 days**

Due to... **Peritonitis, acute fibrino-purulent** 6 days

Due to... **Ulcer of stomach** Unknown

Other conditions... **Adenocarcinoma, left kidney** Unknown
Arteriosclerosis, generalized, mild Unknown
 (Include pregnancy within 8 months of death)

Major findings of operations... **Same as above**

Autopsy results... **Same as above** Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work? ...

23. SIGNATURE... **J. E. TROLLINGER, MD., Chief, Prof. Services**
VAH, Perry Point, Md. Date signed... **3-24-48**

RECEIVED

MAR 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02688

CERTIFICATE OF DEATH

Reg. Dist. No.

94

1. PLACE OF DEATH:

County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifelong
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Cecil
 City or town North East
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Whitaker West

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 11 1874

8. AGE: Years Months Days If less than one day
73 11 16 hrs. min.

9. Birthplace North East Cecil Md
 (Town, county, and state)

10. Usual occupation School Teacher11. Industry or business Retiring12. Name Jesse West13. Birthplace North East Md14. Maiden name Annie E Campbell15. Birthplace Princess Anne Md16. Informant Mrs Leah FowlerAddress North East Md17. Burial Date thereof 3-29-48
 (Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory MethodistLocation North East Md18. Funeral director Joseph P. EvansAddress North East Md19. 3-29 19 48 L. A. & C. Evans
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 March 19 48 at 2:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 46 to March 19 48
 and that I last saw h. alive on 26 March 19 48

Immediate cause of death

Pulmonary Edema

DURATION

30 min.

Due to

Arterio sclerotic Heart Disease5 years

Due to

Other conditions Hypertensive Cardiovascular
Disease

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Klaus H. Huebner M.D.

M. D. or other

Address North East Md Date signed 26 March 48

RECEIVED

APR 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02689

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... **CECIL**
 City or town..... **PERRY POINT, MD.**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **1 month 25 days**
 Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
 How long in hospital or institution? **Same as above**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **1850 Eagle St., Baltimore, Md.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **WW-I**

3. (a) FULL NAME

AUSTIN WILKINS

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife **Rosie Wilkins**
 6. (c) If alive, give age **Unkn.** years
 7. Birth date of deceased (mo., day, yr.) **November 16, 1891**
 8. AGE: Years **56** Months **4** Days **14** If less than one day
 hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Freight Handler**
 11. Industry or business
 FATHER 12. Name..... **Unknown**
 13. Birthplace
 MOTHER 14. Maiden name..... **Unknown**
 15. Birthplace

16. Informant..... **Hospital Records**
 Address..... **VAH, Perry Point, Md.**
 17. Removal **Removal** Date thereof..... **3-31-48**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Baltimore National Cemetery**
 Location..... **Baltimore, Maryland**
 18. Funeral director..... **James E. Doughty**
 Address..... **Havre de Grace, Maryland**
 19. (Date rec'd by registrar) **March 2, 1948**

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **March 30th** 19. **48** at **8** A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 5th 19. **48** to **March 30th** 19. **48**
 and that I last saw him alive on **March 30th** 19. **48**

Immediate cause of death.....
Adenocarcinoma of stomach with
metastases generalized
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)
 Major findings of operations..... **Same as above**
 Date of op.....
 Autopsy results..... **No autopsy**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?.....

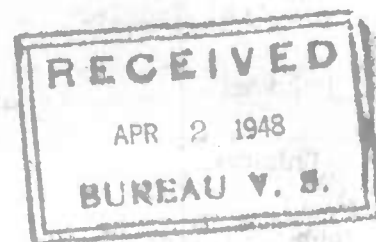
23. SIGNATURE..... **A. E. TROLLINGER, M.D., Chf. Profess. Serv.**
 Address..... **VAH, Perry Point, Md.** Date signed..... **3-31-48**

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

FILE No. G 115 APR 16 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02690

Reg. Dist. No. 92

1. PLACE OF DEATH:

County... Cecil

City or town... Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

122 Collins Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Cecil

City or town... Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 122 Collins Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

Horace M. Willis

3. (b) Social Security Number

195-05-2911

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced X

6. (b) Name of husband or wife Clara Willis

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1892 8. (c) If alive, give age 47 years

8. AGE: Years 55 56 Months Days If less than one day

hrs. min.

9. Birthplace Chester, Pa.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Jacob Willis

13. Birthplace Harrisburg Pa

14. Maiden name unknown

15. Birthplace unknown

16. Informant Clara Willis

Address 122 Collins Street, Elkton Md.

17. Burial, cremation, or removal, Which? Burial Date thereof March 23, 1948
(month) (day) (year)

Cemetery or crematory Providence Cemetery, Elkton Md.

Location Elkton Maryland

18. Funeral director Carl K. Bell

Address 909 Poplar St. N. Del

19. Mar 23, 1948 J. H. Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1948 at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1948 to March 21, 1948

and that I last saw him alive on March 20, 1948

Immediate cause of death Cardiac Asthma

DURATION

7 years

Due to Ch. Myocarditis

Due to Ch. Embolus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James L. Johnson MD

Address 2401 14th St. S. Del

Date signed 3/23/48

CERTIFICATE OF DEATH

1920-2021

RECEIVED
JUN 25 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

02691

186a

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County CecilCity or town Perry Point
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mos. 4 days

Hospital, institution, or street address where death occurred:

VA Hospital, Perry Point, Md.How long in hospital or institution? Since Aug. 1, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County FrederickCity or town Winchester
(If outside city or town limits, write RURAL and give nearest town)Street No. 116 W. Germain Street
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

3. (a) FULL NAME

WISECARVER, Herbert

3. (b) Social Security Number

Unknown

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>white</u>	<u>Single</u>

6. (b) Name of husband or wife ---

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 12, 1893

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>0</u>	<u>16</u>	_____ hrs. _____ min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Unknown

11. Industry or business

12. Name Unknown - deceased13. Birthplace Unknown14. Maiden name Unknown - deceased15. Birthplace Unknown16. Informant Hospital RecordsAddress VA Hospital, Perry Point, Md.17. Removal Date thereof Mar. 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Mt. HebronLocation Winchester, Va.18. Funeral director OMPS FUNERAL HOMEAddress 455 N. Loudon St., Winchester, Va.19. March 28 19 48 Irene S. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 19 48, at 2:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
September 24, 19 47, to March 28, 19 48and that I last saw him alive on March 28, 19 48Immediate cause of death Pneumonia, hypostatic DURATION 3 daysDue to Cerebral and general arterio-sclerosis

Due to _____

Other conditions _____

Fracture, right hip
(Include pregnancy within 3 months of death)Major findings of operations ---

_____ Date of op. _____

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/21/47Where did injury occur? Perry Point, Cecil (County) md (State)Injured at home, farm, industry, public place (where?) HospitalMeans of Injury Fall Injured at work? ---23. SIGNATURE J. E. Trolling

A. E. TROLLINGER, M.D., Chief of Prof. Svcs.

Address VAH, Perry Point, Md. Date signed 3-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02692

Reg. Dist. No. 90

1. PLACE OF DEATH:

County CecilCity or town Cecilton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa. CountyCity or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)Street No. 822 South St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Grace B. York.4. Sex Female 5. Color or race Caucasoid 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Layton York7. Birth date of deceased (mo., day, yr.) February 2 - 19028. AGE: Years 46 Months 1 Days 3 (c) If alive, give age years9. Birthplace Cecilton
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Ferdinand Bacon13. Birthplace Cecilton14. Maiden name Mamie W. Huntington15. Birthplace Cecilton16. Informant Layton YorkAddress 822 South St. - Phila. Pa.17. Burial Date thereof March 8 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cecilton Cem. (Col.)Location Cecilton, Md.18. Funeral director Edward FellowsAddress Millington, Md.19. Mar 8 19. 48 Mrs. Harriet W. Chynoweth
(Date rec'd by registrar) Registrar Address Sparks, Md.

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19. 48 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 19. 48, to March 5 19. 48and that I last saw him alive on March 5 19. 48Immediate cause of death Chronic myocarditisand myocardial degeneration(developed during pregnancyand delivery 8 yrs ago)

Due to

Due to

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Paprocki, M.D.

M. D. or other

Address Sparks, Md.Date signed 3-6-48

